Medicare Advantage
Risk Adjustment Coding
What we’ll cover today

• What’s risk adjustment (RA) coding and why is it done?
• Defining Hierarchical Condition Categories (HCC) and Risk Adjustment Factors (RAF)
• Impacts to providers
• Wellness visits
• CMS audits
• Correct coding guidelines
• Medicare Advantage provider website
• Questions?
What’s risk adjustment and why is it done?
Risk adjustment

A method used to adjust bidding and payment based on the health status and demographic characteristics of an enrollee

Risk adjustment calculations consider:
• Diseases that have significant impact on patient cost of care
• Demographic information such as age and sex

Predictive in nature:
• Information from current year to predict future year expenditures
Why is risk adjustment done?

To accurately reflect the health of our membership:

- Risk adjustment scores are higher for a patient with a greater disease burden, less for a healthier patient.
- The diagnosis codes reported on your claims determine a patient’s disease burden and risk score.
- Chronic conditions must be reported once per year.
- *Each January 1, the RA slate is wiped clean. All your Medicare patients are considered completely healthy until diagnosis codes are reported on claims.*
Hierarchical Condition Categories & Risk Adjustment Factors
What does HCC mean?

• HCC (Hierarchical Condition Categories) is a model implemented by Medicare in 2004 to adjust capitation payments to private healthcare plans for the health expenditure risk of their enrollees

• The CMS risk adjustment model measures the disease burden that includes 70 HCC categories, which are correlated to diagnosis codes
What is an HCC code?

The HCC model is made up of 9,000 ICD-10 codes that typically represent costly, chronic diseases such as:

- Diabetes
- Chronic kidney disease
- Congestive heart failure
- Chronic obstructive pulmonary disease
- Malignant neoplasms
- Some acute conditions (MI, CVA, hip fx)
How is the risk score developed?

- The Risk Adjustment Factor (RAF score) is set for each patient and includes:
  - Baseline demographic elements (age/sex, dual eligibility status)
  - Incremental increases based on HCC diagnoses submitted on claims from face to face encounters with qualified practitioners during the calendar year
- HCC coding is prospective in nature - the work you do in this year sets the RAF and subsequent funding for next year
How is the risk score developed? *Cont.*

- All models include chronic conditions that do not change from year to year, i.e., diabetes, COPD, CHF, Atrial-Fib, MS, Parkinson’s, Chronic Hepatitis
- *Note: Exchange model includes acute conditions pertinent to a younger demographic (pregnancy) and congenital abnormalities*
## Risk adjustment coding example

<table>
<thead>
<tr>
<th>No conditions coded</th>
<th>Some conditions coded</th>
<th>All chronic conditions coded</th>
</tr>
</thead>
<tbody>
<tr>
<td>76-year-old female</td>
<td>0.442</td>
<td>76-year-old female</td>
</tr>
<tr>
<td>Medicaid eligible</td>
<td>0.151</td>
<td>Medicaid eligible</td>
</tr>
<tr>
<td>DM with complications</td>
<td>X</td>
<td>DM w/o complications</td>
</tr>
<tr>
<td>Vascular disease</td>
<td>X</td>
<td>Vascular disease</td>
</tr>
<tr>
<td>CHF</td>
<td>X</td>
<td>CHF</td>
</tr>
<tr>
<td>Disease interaction (DM +CHF)</td>
<td>X</td>
<td>Disease interaction (DM +CHF)</td>
</tr>
<tr>
<td>Total RAF</td>
<td>0.593</td>
<td>Total RAF</td>
</tr>
</tbody>
</table>
Impacts to Providers
Provider view of risk adjustment

I just want to take care of my patients

ICD10, Meaningful use, now what?

This is busy work that only benefits the insurance company

I care about CPT codes

I can only report one diagnosis code per visit...

I am paid to be a doctor - not a coder!
The current model

Reimbursement (and compensation) based on intensity of each individual service (CPT, HCPC codes)

Focus has been on documentation supporting level of service (99213 vs. 99214)

Less emphasis on diagnostic specificity
Risk adjustment will be the future model

Healthcare is rapidly changing

More patients are affected than just Medicare patients

Risk adjustment is now used for ACA and Medicaid

Documentation and coding will increasingly drive reimbursement, quality measures, and medical home models
Premera’s goal

To encourage providers to report diagnosis codes as specifically and accurately as possible

*Diagnosis and procedure codes billed should accurately reflect the level of service supported by the patient’s medical records*
Wellness Visits
Enhanced Annual Wellness Visits

• A typical visit lasts 45-60 minutes, at no-cost to the patient, including preventive labs
• The goal is to see every Medicare patient every year and for this service to be billed once per calendar year
• The benefit refreshes January 1 of every year; no need to wait 365 days between visits
• In addition to the traditional AWV CPT codes G0438 and G0439, Premera allows for an additional code of S0250 (3.0 RVU) to cover the extra time of assessing chronic conditions
• Visits need to be performed by a primary care physician, contracted nurse practitioner, or PA
During an Enhanced Annual Wellness Visit

- Document patient’s current chronic conditions and ongoing treatment plans
- Conduct preventive screenings for conditions such as high blood pressure, diabetes, depression, and heart disease
- Review medications
- Schedule preventative treatments: colonoscopy, blood work, mammogram, etc.
- Complete lab work as necessary
- Use a pre-populated template from Premera
- Fax chart notes to us at the end of the visit to receive payment; 855-574-8145
Benefits of an Enhanced Annual Wellness Visit

- Allows for accurate reporting/submission of patient’s chronic conditions to Medicare in the current year
- Maintains best practice of seeing your patients at least once a year
- Allows opportunity to identify care gaps and create a plan of care for the year
- Ensures acceptable medical record documentation in the case of a Risk Adjustment Data Validation (RADV) audit. Compliance with Star Measures is also required by CMS.
Other considerations

CMS measures outcomes in multiple domains, including measures focused on your efforts to manage chronic conditions/issues in the Medicare population:

- Osteoporosis
- Diabetes (retinopathy, nephropathy, HgbA1c, and cholesterol control)
- Hypertension
- Rheumatoid arthritis
- Bladder control
- Fall risk

The quality measures integral to the Enhanced Wellness Visit allows Premera to partner with providers in managing these patients.
CMS Audits
Risk adjustment data validation (RADV)

• RADV audits *validate the accuracy of diagnoses* submitted by MA plans
• Medicare, Medicaid, and Dept. of Health and Human Services (Exchanges) will require annual RADV audits
• If you treated a member whose name appears in a RADV audit, you provide the requested medical records
• **Success = accurate chart notes to support every chronic condition you report**
• **Average error rate nationally is 20–30%**
Correct coding guidelines
### Factors that can affect a patient’s diagnostic picture

| Not seeing their PCP each year. This might be for many reasons, and through no fault of the PCP | Patient with chronic conditions not monitored = chronic conditions not treated | Patient seen infrequently for other problems, without updating and documenting chronic conditions |
Diagnostic coding guidelines

• ICD-10 includes Official Guidelines for Coding and Reporting. Adherence to these guidelines is required under HIPAA

• Documentation must show that condition was monitored, evaluated, assessed, or treated (MEAT)

• A diagnosis code may only be reported if it is explicitly spelled out in the medical record
  • No coding from problem lists, super bills, or medical history
  • Treatment is *prima facia* evidence of a diagnosis—if you’re treating, it therefore exists
MEAT the chronic condition

Monitor
- Signs, symptoms, disease progression, disease regression

Evaluate
- Test results, medication effectiveness, response to treatment

Assess/Address
- Ordering tests, discussion, review records, counseling

Treatment
- Medications, therapies, other modalities

Examples:
- CHF: I50- symptoms well controlled with Lasix and ACE inhibitor. Will continue current medications
- Recurrent major depression: F33.9- Patient continues with feelings of hopelessness and anhedonia despite current regimen of Zoloft 50 mg daily. Will increase dose to 100 mg daily and monitor
Diabetes ICD-9: What was needed?

- Is it Type 1, or Type II, or secondary DM?
- Is it Controlled or Uncontrolled?
  - Fifth-digit sub-classification is for use with category
    - 250.0X
    - 0 – Type II or unspecified type, not stated as uncontrolled
    - 1 – Type I (juvenile type), not stated as uncontrolled
    - 2 – Type II or unspecified type, uncontrolled
    - 3 – Type I (juvenile type), uncontrolled
Diabetes ICD-10: What’s needed now?

What type is it?

Five categories to choose from: Over 100 new codes

1. Diabetes mellitus due to underlying condition (E08._)
2. Drug or induced diabetes mellitus (E09._)
3. Type I diabetes mellitus (E10._)
4. Type II diabetes mellitus (E11._)
5. Secondary diabetes mellitus NEC (E13._)

Example: E11.9 Type 2 diabetes mellitus without complications

- If DM is inadequately controlled, poorly controlled, or out of control then reference DM (by type) with hyperglycemia.
- Example (E11.65)
- Use additional code for Insulin use (Z79.4)
ICD-10 notes for diabetes

Most manifestations are built into the code, which means that a second code to identify the specific manifestation is not always required in ICD-10

Exceptions:

- Chronic Kidney disease - Use additional code to identify stage of chronic Kidney disease (N18.1—N18.6)
- Ulcers:
  - Use additional code to identify site of foot ulcer. (L97.4_ thru L97.5_)
  - Use additional code for other skin ulcers (L97.1-L97.9, L98.41-L98.49)
- Other DM Manifestations: Use additional code to identify complication of diabetes
- Use additional code to identify any insulin use (Z79.4)
Documenting & Coding: Make the link

Any manifestations must be documented as a cause and effect relationship, for example:

- **Lower Complexity**
  - **Assessment:** 1. DM 2. Polyneuropathy
  - Can only code: **E11.9** and G62.9 (ICD-10-CM)

- **Higher complexity**
  - **Assessment:** 1. DM *with* Polyneuropathy
  - Can code: **E11.42** (ICD-10-CM)

Under-documenting DM communicates a less serious DM case, which reflects an inaccurate picture of the patient’s health status.
Documentation examples for DM

**Chief Complaint:** “I am here for my quarterly evaluation of my diabetes.”

*Patient is a 50-year-old woman with Type 1 diabetes since childhood. She’s been on insulin since age 13. As a result of her diabetes she has chronic kidney disease and is currently on dialysis for ESRD. She also has diabetic neuropathy affecting both lower extremities.*

**Review of Systems, Physical Exam, Laboratory Tests:**

- No changes in underlying condition during the last 3 months. She continues to perform self-testing of her blood sugar levels on a daily basis, is on dialysis every other day, most recently 24 hours ago, and has not noticed any changes in the numbness in her legs.
- VSS, BP 140/75, P 80, R 16 and T 98.8
- Dialysis fistula without any signs of infection
- Decreased sensation over lower extremities below the knees
- Lab: BUN/Cr nl, K+ 3.5, glu 105, Hgb A1c 7.9
Documentation examples for DM

Coding:
1. **E10.22** - Type 1 diabetes mellitus with diabetic chronic kidney disease
2. **N18.5** - Chronic kidney disease, stage 5
3. **E10.42** - Type 1 diabetes mellitus with diabetic polyneuropathy
4. **Z99.2** - Dependence on renal dialysis
A-Fib: Same concepts in ICD-9 & ICD-10

What type:
Paroxysmal, persistent, chronic, typical, atypical, unspecified

- ICD-9 code A-Fib 427.31, A-Flutter 427.32

ICD-10 Diagnosis Code:

- I48.0 Paroxysmal atrial fibrillation
- I48.1 Persistent atrial fibrillation
- I48.2 Chronic atrial fibrillation
- I48.3 Typical atrial flutter
- I48.4 Atypical atrial flutter
- I48.91 Unspecified atrial fibrillation
- I48.92 Unspecified atrial flutter

*Note - Sinoatrial node dysfunction 427.81 maps to two separate conditions:
- R00.1. Bradycardia, unspecified (lower specificity)
- I49.5 Sick sinus syndrome which carries risk (HCC 96)
Heart Failure ICD-9: What was needed?

• Is it congestive Heart failure? (Left, Acute, chronic, systolic, diastolic, both)
  • Congestive Heart failure: 428.0 - 428.9
• Was it due to Hypertension?
  • Hypertensive Heart disease- 402.0-402.9
    • (use additional code to identify type of Heart failure 428.0-428.9)
      • Hypertensive Heart and CKD 404.0-404.9
        • (use additional code to identify stage of CKD 585.1-585.4, 585.9)
• Is there coronary artery disease? (Native or graft)
  • Coronary Artery Disease 414.0X (No HCC)
• Is there angina or an old MI?
  • Angina 413.x
  • Old MI 412
Heart Failure: ICD-10 What’s needed now?

- Describe the type of (congestive) heart failure:
  - Systolic I50.2
  - Diastolic I50.3
  - Both systolic and diastolic I50.4
  - Unspecified I50.9
- Note the stability as being acute, chronic or acute on chronic. This will determine 0-3 for the 5th digit
- Was it due to Hypertension?
  - Hypertensive Heart Disease I11
  - For I11.0 Hypertensive heart disease with heart failure
  - Use additional code to identify type of heart failure I50._
Heart Failure: ICD-10 What’s needed now?

- Hypertensive Chronic Kidney Disease (I12)
  - Use additional code to identify stage of CKD N18.1-N18.4, N18.9
- Is there Coronary Artery Disease (Native or Graft)
  - Atherosclerotic Heart Disease of native coronary artery without Angina (I25.10- NO HCC)
  - Atherosclerotic Heart Disease of native coronary artery with Angina
    - I25.110 unstable angina pectoris
    - I25.111 with documented spasm
    - I25.118 with other forms of angina pectoris
    - I25.119 with unspecified angina pectoris
- Is there angina?
  - Angina I20.9
  - Old MI I25.2 –(No HCC)
Chronic Kidney Disease: ICD-9 What was needed?

- Document the stage of CKD (based on GFR if available)
  - Chronic kidney disease, stage 1 585.1
  - Chronic kidney disease, stage 2 (mild) 585.2
  - Chronic kidney disease, stage 3 (moderate) 585.3
  - Chronic kidney disease, stage 4 (severe) HCC 585.4
  - Chronic kidney disease, stage 5 HCC 585.5
  - End-stage renal disease (ESRD) HCC 585.6
- Code any underlying conditions such as DM or Hypertensive kidney disease, if applicable, (403.00-403.91, 404.00-404.93)
- Use additional code to identify renal dialysis status, if applicable HCC (V42.11)
Chronic Kidney Disease: ICD-10 What’s needed now?

- Document the stage of CKD (based on GFR if available)
  - Chronic kidney disease, stage 1 N18.1
  - Chronic kidney disease, stage 2 (mild) N18.2
  - Chronic kidney disease, stage 3 (moderate) N18.3
  - Chronic kidney disease, stage 4 (severe) HCC N18.4
  - Chronic kidney disease, stage 5 HCC N18.5
  - End-stage renal disease (ESRD) HCC N18.6

- Document any underlying cause of CKD such as Diabetes or Hypertension

- Document if the patient is dependent on Dialysis HCC Z99.2

- Chronic renal failure without a documented stage will be assigned to chronic kidney disease, unspecified

- Document any associated diagnoses/conditions
Depressive Disorder IN ICD-10 (F32-F33)

- Document episode:
  - Single or Recurrent
- Document severity:
  - Mild, Moderate or Severe
    - With psychotic features or without psychotic features
- In partial or full remission (if applicable)
- For example: Major depressive disorder, single episode, moderate F32.1
- Caution: Major Depression: 296.20 (HCC 58) maps to F32.9 (No HCC)
  - However 296.21-296.26 maps to F32.0-F32.5 (HCC 58) (HCC).
  - You must specify whether the depression is mild, moderate or severe
Chronic Obstructive Pulmonary Disease: ICD-9 What was needed?

- ICD-9 Diagnosis Code: Chronic obstructive pulmonary disease unspecified 496
  - Is it Asthma
  - Is it Bronchitis
  - Is it Emphysema?
  - Is there an obstructive component
  - Is this acute or chronic?
  - Is there an acute respiratory infection
  - Is this an exacerbation
- Obstructive Chronic Bronchitis: 491.0
- Emphysema 492.8
- Chronic obstructive Asthma 493.20
Chronic Obstructive Pulmonary Disease: ICD-10 What’s needed now?

- ICD-10 Diagnosis Code: Chronic obstructive pulmonary disease unspecified J44.9
  - Is it Asthma?
  - Is it Bronchitis?
  - Is it Emphysema?
  - Is there an obstructive component?
  - Is this acute or chronic?
  - Is there an acute respiratory infection with the COPD?
  - Is this an exacerbation?
  - Is this due to tobacco use? (Z72.0)
- Chronic bronchitis J42
- Emphysema J43.9
- Asthma J45
  *Add additional code for chronic obstructive pulmonary disease J44.9 (HCC 111)
  - Documentation: Frequency, state of the asthma, triggers of the asthma
  - Mild intermittent, Mild persistent, Moderate persistent, Severe persistent?
Peripheral Arterial/Vascular Disease (PAD) (PVD): ICD-9 What was needed?

ICD-9 Dx Code: 443.9-PAD, PVD, intermittent claudication
Atherosclerosis of extremity 440.2
• Are there symptoms or complications such as rest pain, caudation or ulcers, gangrene?
• Are these native arteries, is this a graft?

440.9 Arteriosclerotic vascular disease NOS
440.20 Atherosclerosis of native arteries of the extremities, unspecified
440.21 Atherosclerosis of native arteries of the extremities, with intermittent claudication
440.22 Atherosclerosis of native arteries of the extremities, with rest pain
440.23* Atherosclerosis of native arteries of the extremities, with ulceration
440.24* Atherosclerosis of native arteries of the extremities, with gangrene
440.29 Atherosclerosis of native arteries of the extremities, other
Peripheral Arterial/Vascular Disease: ICD-9 What was needed? (cont.)

* Use additional code to identify any associated ulcer: 707.1X
  • When PAD or atherosclerosis is documented as a manifestation of diabetes or secondary diabetes, report one of the following diabetes codes with the associated manifestation code:
    • 250.70 Diabetes with peripheral circulatory disorders, type II or unspecified
Peripheral Arterial/Vascular Disease (PAD) (PVD): ICD-10 What’s needed now?

• PAD and PVD unspecified I73.9
• Atherosclerosis of extremity I70-2* - I70.8
  • What is the laterality - Right leg, left leg, both?
  • Are there symptoms or complications such as rest pain, caudation or ulcers, gangrene?
  • Are these native arteries I70.2* or is this a graft I70.3*
• Example: arteriosclerosis of the native arteries of legs with intermittent claudication bilaterally
  • I70.20* Unspecified atherosclerosis of native arteries of extremities
  • I70.21* Atherosclerosis of native arteries of extremities with intermittent claudication
  • I70.22* Atherosclerosis of native arteries of extremities with rest pain
  • I70.23* Atherosclerosis of native arteries of right leg with ulceration
  • I70.24* Atherosclerosis of native arteries of left leg with ulceration
  • I70.25* Atherosclerosis of native arteries of other extremities with ulceration
Peripheral Arterial/Vascular Disease: ICD-10 What’s needed now? (Cont.)

- Use additional code to identify the severity of the ulcer (L98.49-)
  - I70.29 Other atherosclerosis of native arteries of extremities
- Use additional code, if applicable, to identify chronic total occlusion of artery of extremity (I70.92)
- When PAD or atherosclerosis is documented as a manifestation of diabetes, report the following combination code
  - E11.51 Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene
  - E11.52 Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene
- FACT- Atherosclerotic disease is a progressive disease. Therefore, avoid documenting “history of peripheral vascular disease” and instead consider “known peripheral arterial disease.”
Peripheral Arterial/Vascular Disease: ICD-10 What’s needed now? (Cont.)

Use additional code (L97.***Non-Pressure chronic ulcer of ______) to report:

- Laterality: right, left, bilateral
- Location of ulcer: thigh, foot, calf, ankle, mid foot
- Severity of the ulcer: limited breakdown of skin, fat layer exposed, necrosis of muscle, necrosis of bone

L97.*** Non-pressure chronic ulcer of lower limb, not elsewhere classified

L97.1** Non-pressure chronic ulcer of thigh
L97.5** Non-pressure chronic ulcer of other part of foot
L97.2** Non-pressure chronic ulcer of calf
L97.8** Non-pressure chronic ulcer of other part of lower leg
L97.3** Non-pressure chronic ulcer of ankle
L97.9** Non-pressure chronic ulcer of unspecified part of lower leg
L97.4** Non-pressure chronic ulcer of heel and midfoot

When documenting ulcers, it is important not to document them as “wounds,” “open wounds” or “lesions.”
Oncology: Same ICD-9 & ICD-10

• Per coding guidelines, cancers are coded by their location and may only be coded as active when current treatment is being directed to the cancer, or if the cancer is active and treatment was refused.

• Use a personal history code for patients who have completed treatment, even if they’re being monitored for a recurrence.
ICD-9

- Breast 174.9
- Prostate 185
- Bladder 188.9
- Lung 176.4

ICD-10

- Breast C50.9** (male/female)
- Prostate C61
- Bladder C67.9
- Lung C34.9* (right/left)
CVA: Late effects or history of CVA?

- **Personal history of CVA with no late effects**
  - Z86.73 – Transient ischemic attack, and cerebral infarction w/out residual deficits

- **Personal history of CVA with late effects**
  - I69.___ – Late effects of cerebrovascular disease
    - I69.___ – Hemiplegia/hemiparesis
    - I69.___ – Monoplegia of upper limb
    - I69.___ – Monoplegia of lower limb
    - I69.___ – Other paralytic syndrome
Rheumatoid Arthritis: ICD-9 vs ICD-10

- ICD-9 Rheumatoid arthritis 714.0
  - Juvenile chronic polyarthritis 714.3X
- ICD-10- Rheumatoid Arthritis M05-M14 (over 700 codes)
- Code sets explode!
  - Rheumatoid myopathy
  - Rheumatoid polyneuropathy
  - With/without rheumatoid factor
  - With Organ or system involvement
  - Rheumatoid bursitis
  - Rheumatoid nodule
  - Other specified rheumatoid arthritis
  - *Where is the rheumatoid arthritis located, i.e. shoulder, wrist, ankle*
- Other Rheumatoid arthritis with rheumatoid factor of multiple sites (HCC) *ICD-10 Diagnosis Code: M05.89*
Fractures in ICD-10

• Cause
  • Traumatic, stress,
  • Pathologic (osteoporosis, disuse, drug-induced, postmenopausal, idiopathic, postsurgical malabsorption, neoplastic disease)

• Document location
  • Bone (distal, proximal, shaft, etc.)
  • Laterality

• Type
  • Non, displaced, displaced, open, closed

• Document encounter type:
  • Initial encounter
  • Subsequent encounter
    • Routine healing
    • Delayed healing
    • Nonunion
    • Malunion

Example:
  • Greenstick fracture of shaft of humerus, right arm, subsequent encounter S42.311D
  • Age-related osteoporosis with current path fracture, vertebra(e), initial M80.08XA
Pathological Vertebral Fractures

- Pathological fracture vertebrae **733.13** (HCC 169) maps to M84.48XA Pathological fracture, other site, initial encounter for fracture (No HCC).
- However it also maps to two other ICD-10 codes:
  - **M48.50XA** (Collapsed vertebra, NEC, site unspecified, initial encounter for fracture) HCC 169
  - **M80.08XA** (Age-related osteoporosis with current path fracture, vertebra(e), initial encounter for fracture) HCC 169
Chronic Hepatitis: ICD-9 vs ICD-10

• Document acuity:
  • Acute
  • Chronic

• Document etiology:
  • Alcoholic
  • Drug (specify)
  • Viral (Type A, B, C, or E)

• Document also:
  • With hepatic coma
  • Without hepatic coma
  • With delta agent
  • Without delta agent

• Example: Chronic viral hepatitis C B18.2
Chronic Hepatitis:  ICD-9 vs ICD-10

• **Chronic Viral Hepatitis**
  • Chronic viral hepatitis B with delta-agent  B18.0
  • Chronic viral hepatitis B without delta-agent  B18.1
  • Chronic viral hepatitis C  B18.2
  • Other chronic viral hepatitis  B18.8
  • Chronic viral hepatitis, unspecified  B18.9

• **Alcoholic cirrhosis of liver  571.2**
  • K70.30 Alcoholic cirrhosis of liver without ascites
  • K70.31 Alcoholic cirrhosis of liver with ascites

• **Chronic hepatitis, unspecified  571.40**
  • K73.9 Chronic hepatitis, unspecified

• **Chronic persistent hepatitis  571.41**
  • K73.0 Chronic persistent hepatitis
Obesity

- Nonspecific:
  - Obesity, unspecified E66.9

- Specific
  - Morbid Obesity E66.01
  - Body mass index 40.0-44.9 Z68.41
  - Body mass index 45.0-49.9 Z68.42
  - Body mass index 50.0-59.9 Z68.43
  - Body mass index 60.0-69.9 Z68.44
  - Body mass index 70.0 and over Z68.45
**Document patients’ status conditions**

**ICD-10 - most will be Z codes**

- Asymptomatic HIV infection status **Z21**
- Organ or tissue transplant status  
  • Heart **Z94.1**
- Artificial opening status **Z93.XX**  
  • Tracheostomy
- Gastrostomy, ileostomy, colostomy  
  • Cystostomy, ureterostomy, urethrostomy
- Amputation status
- Renal dialysais status (or non-compliance) **Z99.2**
- Morbid obesity; **E66.01, Z68.4X**
- Paraplegia; paralysis, both lower limbs
- Diplegia; paralysis, both upper limbs
- Hemiplegia, late effect of CVA **I69.35X**
- Hemiplegia, unspecified **G81.9X**
ICD-10 Status Codes

- Obesity-Morbid (severe) must have BMI >40
- Morbid obesity  E66.01
  - Body Mass Index (BMI) Z68.4X
  - Document any associated diagnoses/conditions
- Above the Knee Amputation Status (HCC) Z89.612
- Lower Limb amputations Z89.4**, Z89.5**, Z89.6**
- Colostomy status (HCC)
  - Artificial opening status – colostomy Z93.3
- Parkinson disease, symptomatic - ICD-10 Diagnosis Code : G20
Documentation pitfalls: Qualifying language

Under ICD-9 guidelines, “Personal history (of)” means a past medical condition that no longer exists.

“History of” is an often misused descriptor. Never use this term to describe a condition that the patient still has.

Frequently seen examples:
- “History of CHF” misused to indicate compensated CHF
- “History of Afib” misused to indicate atrial fibrillation controlled by medication or pacemaker
Medicare Advantage Provider Website
PCP Member Roster Report: Medicare

This tool will allow you to search for PHP Medicare and Medicaid members assigned to individual providers as a PCP within your clinic. Select an individual provider from the drop down menu and click **SEARCH**. Thank you for using ProvLink.

Select Providers:  
- ABANO, JOHN B.
- ACUNA-EATON, INGRID L.
- ALEXANDER, WENDI D.
- ANDERSON, CLINTON W.
- ANDREONI, MICHAEL J.
- ARGUE, LEE R.
- BLUE, SUSAN M.
- BOYD, RAE
- BUMSTEAD, KATHERINE D.
- BURSON, SEAN M.
- CADENA-FORNEY, GINA A.
- CHISHOLM, JOHN D.
- CHOI, ROBERT Y.
- CLARKSON, THOMAS A.
- CLOSS-BREWER, MELISSA L.
- CLYNE, VICTORIA E.
- COFFMAN, WENDY J.
- CULVER, JOLENE A.
- DASTVAN, CELIA M.
- DAVIS, KARINE J.
- DE CASTRO, GARRET G.
- DECHADENEDES, NICHOLAS B.
- DHANKI, CATHERINE J.
- DIAZ, GEORGE A.
PCP roster - results

PCP Member Roster Report: Medicare

This tool will allow you to search for PHP Medicare and Medicaid members assigned to individual providers as a PCP within your clinic.

Select an individual provider from the drop down menu and click SEARCH.

Thank you for using ProvLink.

Select Providers: CHISHOLM, JOHN D.  
Select by Tax ID: 

Search Cancel

Search returned 10 records.

<table>
<thead>
<tr>
<th>Member ID</th>
<th>Member Name</th>
<th>DOB</th>
<th>Sex</th>
<th>Effective Date</th>
<th>Address</th>
<th>Phone #</th>
<th>Term Date</th>
</tr>
</thead>
</table>

Export to Excel

PREMERA
BLUE CROSS
Annual wellness visit

**Annual Wellness Visit Reports**

To ensure appropriate reimbursement for services rendered to Medicare members an annual wellness visit is required to document the existing conditions of the Medicare members assigned to your clinic’s PCPs, indicates the current risk score, documented conditions and when the last Wellness Visit occurred for each member or export a partial report to excel. If you need a guide for your annual visit, please utilize the Annual Wellness Visit Blank Template for required to be submitted to the Health Plan.

- **By PCP:**
- **By Clinic:**
- **By Member ID:**
- **By New To Clinic:**

**DISCLAIMER:** All Information contained within reports is generated from claims data with no actual medical record review. It is possible you will find another treating provider. This is especially true for “Conditions” which is meant as a guide for the treating physician but should never be used as
Select the patients you want more information on, including last wellness visit date and conditions. Once selected, you can generate a report.
Essential takeaways for today and tomorrow

• Risk adjustment will become a more prevalent part of a provider’s patient care
• The importance of consistent, accurate, and complete documentation in the medical record can’t be overemphasized
• Documentation and specificity are the keys to success
Questions?
Thank you